BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
	No. 17-92-17011
JOHN ANDREW McRAE, M.D.	OAH No. L-9506144
Physician's and Surgeon's Cert. No. C-24327,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on **October 10, 1997**.

IT IS SO ORDERED **September 10, 1997**.

MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____

ANABEL ANDERSON IMBERT, M.D.
Presidnet
Division of Medical Quality

btm

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against JOHN ANDREW McRAE, M.D. Physician and Surgeon's Certificate No. C-24327 Respondent.	NO. 17-92-17011 OAH NO. L9506144

PROPOSED DECISION

This matter was heard on July 21, 22, 23, 24, 25 and 28, 1997, at Los Angeles, California, by Jerry Mitchell, Administrative Law Judge of the Office of Administrative Hearings, State of California. The complainant was represented by Robert McKim Bell, Deputy Attorney General. The respondent was present and was represented by David O'Keefe and Gregory D. Werre, Attorneys at Law.

FACTUAL BASIS

1. The Amended Accusation herein was made by Doug Laue in his official capacity as Acting Executive Officer of the Medical Board of California.

2. Since July 31, 1962, John Andrew McRae (hereinafter "respondent") has been licensed as a physician and surgeon under certificate number. C-24327.

3. Respondent was negligent and incompetent in that on June 6, 1990, at the Hospital of the Good Samaritan in Los Angeles, California, while attempting to perform an anterior C5-6 discectomy and fusion, using a bone bank plug, on patient M. B., respondent relied upon an inadequate X-ray to locate C5-6, mistook C4-5 for C5-6, and performed the discectomy and fusion at C4-5 instead of at C5-6.

4. It is alleged that respondent knowingly made a false statement with fraudulent intent as follows: On June 9, 1990, M.B.

was discharged from the hospital. Respondent stated in M.B.'s discharge summary that "[p]ostoperative AP and lateral cervical spine films show good positioning of the C5-6 interbody fusion and excellent alignment." That statement was false. An X-ray of M.B. taken on June 8, 1990, showed the bone plug at C4-5, and no other film respondent looked at could have shown it at C5-6 because respondent never put it there. However, the allegations that he knew the statement was false and that he made it with fraudulent intent were not proved by clear and convincing evidence.

5. Respondent was negligent and incompetent in that when M.B. told him during the summer of 1990 that he was having the same symptoms he had before the discectomy and fusion, respondent incorrectly diagnosed "resorbtion" of the bone plug he had inserted on June 6th as the cause of M.B.'s persistent symptoms, and he offered to "refuse" C5-6 for M.B.

6. M.B. consented to have respondent "refuse" C5-6, and was readmitted to the Hospital of the Good Samaritan for that purpose. On August 17, 1990, M.B. was in the process of being anesthetized and respondent had not begun to operate when respondent came to the realization that it was not C5-6, but C4-5, that he had previously fused; therefore, he would not be performing the "refusion" to which M.B. had consented. However, instead of waiting until M.B. regained consciousness so he could be given the facts and an opportunity to consent or not to having respondent operate on him again, respondent was negligent and incompetent in that he proceeded to perform an anterior C5-6 discectomy and fusion on M.B. without M.B.'s informed consent.

7. It is alleged that respondent knowingly made another false statement with fraudulent intent by making a note dated August 16, 1990, in M.B.'s progress record as follows: "reopen cervical 5-6 ....." It is true that respondent made the false statement. However, August 16th was the day before he realized that he had not previously fused C5-6.

8. On August 18, 1990, at about 8:30 a.m., respondent visited M.B. in his room at the hospital, then left and although nothing of consequence prevented him from returning earlier, did not return to the hospital until about 7:15 p.m. During his absence, the following occurred:

At about 11:30 a.m. and 1:50 p.m, respondent received telephone calls from nurses at the hospital who expressed concern to him about M.B.'s condition.

At about 3:00 p.m., the anesthesiologist who had anesthetized M.B. on both June 6 and August 17, 1990, looked in on him and reported to respondent by telephone that M.B. was complain

ing of difficulty breathing. Respondent accepted the anesthesiologist's offer to order blood gases and a chest X-ray, and to have a pulmonologist examine M.B.

Immediately after speaking to the anesthesiologist, respondent telephonically ordered M.B. transferred to the intensive care unit. The order was countermanded by an unidentified person, but respondent did not become aware of that fact and could not rectify it because he did not check on M.B. after giving the order.

At about 6:00 p.m. the pulmonologist arrived, found M.B. in severe respiratory distress, diagnosed an upper airway obstruction, and attempted to perform a bronchoscopy and endotrachial entubation. In the process, M.B., who had a preexisting heart condition, developed cardiopulmonary arrest and died at about 7:51 p.m.

9. It was asserted that M.B.'s breathing difficulties were caused by a postoperative hematoma that could have been relieved surgically if respondent had arrived earlier. However, no hematoma was found at autopsy and although its absence could have resulted from efforts to perform a tracheostomy on M.B. shortly before he died, the evidence offered to prove the assertion was less than clear and convincing.

10. Although it was not proved by clear and convincing evidence that there was a causal relationship between respondent's conduct and M.B.'s death, respondent's failure to return to the hospital for about four hours after ordering M. B. transferred to intensive care, and his failure to check on M.B.'s condition and whereabouts in the interim, would constitute negligence and incompetence on respondent's part even if M.B. had survived.

11. On July 19, 1990, respondent attempted to decompress another patient (M.C.) at L4-5 and insert pedicle screws for stabilization, but he relied upon inadequate image amplification, mistook L3 for L4, decompressed L3 instead of L4-5, and inserted pedicle screws at L2-3. However, there were factors that preclude a finding that respondent was negligent or incompetent, to wit: M.C. was short and obese; she had had a number of previous spinal operations that had obscured or obliterated indentifying features on her spine; the lowest moveable segment on her spine was found at a higher level than could be anticipated; dural tearing and leakage occurred during the procedure; the image amplifier that was available was not as good as one that had been available on other occasions, and the image amplifier operator with whom respondent had rehearsed the procedure went off shift while surgery was in progress and was replaced by another operator.

12. Respondent has retired from active practice.

13. The Division's actual and reasonable costs of investigation and enforcement of this case total $45,997.69.

LEGAL BASIS

14. Respondent has subjected his physician and surgeon's certificate to disciplinary action under Section 2234(c) of the Business and Professions Code by his commission of repeated negligent acts in the care and treatment of patient M.B., as set forth in paragraphs 3, 5, 6 and 10.

15. Respondent has subjected his certificate to disciplinary action under Section 2234(d) of the Business and Professions Code by his incompetence in the care and treatment of patient M.B., as set forth in paragraphs 3, 5, 6 and 10.

ORDER

Physician and Surgeon's Certificate No. C-24327, heretofore issued to respondent John Andrew McRae, is revoked. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions. Within 15 days after the effective date of this decision, respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. Within 90 days of the effective date of this decision, respondent shall submit to the Division or its designee for prior approval, a clinical training or educational program. The exact number of hours and specific content of the program shall be determined by the Division or its designee. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Division or its designee related to the program's contents.

2. Respondent shall take and pass an oral clinical exam in a subject to be designated and administered by the Division, or its designee. This examination shall be taken within 90 days after the effective date of this decision. If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of a written as well as an oral examination. The waiting period between the first and second examinations shall be at least three months. If respondent fails

to pass the first and second examinations, respondent may take a third and final examination after waiting a period of one year. Failure to pass the oral clinical examination within 18 months after the effective date of this decision shall constitute a violation of probation. The respondent shall pay the costs of all examinations.

3. Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical

training program approved by the Division, or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

4. Within 30 days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee. If the monitor resigns or is no longer available, respondent shall, within 15 days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

5. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

6. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

7. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record. Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

8. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

9. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

10. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. The respondent is hereby ordered to reimburse the Division the amount of $45,997.69 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his/her responsibility to reimburse the Division for its investigative and prosecution costs.

13. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

14. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs

shall be payable to the Division at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.

DATED: AUGUST 18, 1997

JERRY MITCHELL
Administrative Law Judge

REDACTED

DANIEL E. LUNGREN, Attorney General
of the State of California
ROBERT McKIM BELL,
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 5212
Los Angeles, California 90013-1204
Telephone: (213) 897-2556

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOHN ANDREW McRAE, M.D. 1300 North Vermont Avenue, No. 309 Los Angeles, California 90027 Physician and Surgeon's Certificate No. C-24327, Respondent.	NO. 17-92-17011 AMENDED ACCUSATION

Complainant alleges:

PARTIES

1. Complainant, Doug Laue, is the Acting Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about July 31, 1962, Physician and Surgeon's Certificate No. C-24327 was issued by the Board to John Andrew McRae, M.D. (hereinafter "respondent"), and at all times relevant to the charges brought herein, this license has been in full

force and effect. Unless otherwise renewed, it expired on December 31, 1994.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Section 2220 which provides:

"Except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating the provisions of this chapter. The division shall enforce and administer the provisions of this article as to physician and surgeon certificate holders, and the division shall have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars

($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of an unusually high number of judgments, settlements, or arbitration awards against a physician and surgeon."

B. Section 2227 which provides:

"A licensee whose matter has been heard by the Division of Medical Quality, by a medical quality review committee or a panel of such committee, or by an administrative law judge, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

"(a) Have his or her certificate revoked upon order of the division.

"(b) Have his or her right to practice suspended for a period not to exceed one year upon order of the division or a committee or panel thereof.

"(c) Be placed on probation upon order of the division or a committee or panel thereof.

"(d) Publicly reprimanded by the division or a committee or panel thereof.

"(e) Have such other action taken in relation to discipline as the division, a committee or panel thereof, or an administrative law judge may deem proper."

C. Section 2234 which, in relevant part, provides:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) . . .

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) . . . ."

D. Section 2261 which provides:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

E. Section 2262 which, in relevant part, provides:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct."

F. Section 125.3 which, in relevant part, that:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of investigation and enforcement of the case.

". . . ."

FIRST CAUSE OF ACTION

(Gross Negligence: Patient Miguel B[redacted] [1/])

4. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that respondent committed gross negligence in the care and treatment of patient Miguel B[redacted], as follows:

A. On or about June 6, 1990, patient Miguel B[redacted] who suffered from a cervical disc problem with radiculopathy at the C-5-6 level was admitted to the Hospital of the Good Samaritan Hospital, located in Los Angeles, California, for anterior disc excision and fusion surgery. The surgery which was scheduled for the following day was performed by respondent.

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1. In order to protect patient privacy rights, all patient references in this pleading shall be by initials only. The true names of the patient(s) shall be disclosed to respondent upon his timely written request for discovery as provided for the Administrative Procedure Act.

B. The standard of care in the medical community for anterior disc excision and fusion requires correct localization of the level by x-ray because there are no internal landmarks by which to count or localize vertebral levels accurately when operating by the anterior approach. The x-ray taken of patient Miguel B[redacted] prior to the June 6th surgery was inadequate as it only showed the patient's vertebral column down to C-4. Respondent, who knew or should have known that this x-ray was inadequate to determine the location of the patient's C-5-6 vertebrae, did not have additional x-rays taken of the patient to insure correct counting of the vertebrae and, rather than discontinuing the surgery, proceeded with the operation, erroneously performing the anterior disc excision and fusion surgical procedures at the wrong vertebral level: namely, C-4-5.

C. On or about June 8, 1990, post-operative x-rays were taken of patient Miguel B[redacted]'s lumbar spine region and examined by respondent. Respondent knew or should have known that the June 6th surgery had been performed at the wrong vertebral level. Respondent, however, said nothing and patient Miguel B[redacted] was discharged on June 9, 1990.

D. On or about June 12, 1990, patient Miguel B[redacted] saw respondent at the latter's office, complaining of neck pain. X-rays of patient's neck and

back area were taken. Respondent examined the x-rays and interpreted them to show resorption of the bone plug. Respondent then scheduled patient Miguel B[redacted] for additional back surgery: namely, refusion with autologous iliac crest bone.

E. On or about August 16, 1990, patient Miguel B[redacted] was readmitted to the Hospital of the Good Samaritan for the purpose of having the additional back surgery performed by respondent the following day, August 17, 1990. Before beginning the surgery and after patient Miguel B[redacted] had been anesthetized, respondent reviewed patient Miguel B[redacted]'s x-rays and discovered that the June 6th surgery had been performed at the C-4-5, rather than the C-5-6, level. Without advising patient Miguel B[redacted] of the error or obtaining the consent of patient Miguel B[redacted] or anyone else authorized to give consent on patient Miguel B[redacted]'s behalf, respondent performed the original surgical procedure: namely, anterior disc excision and fusion at the C-5-6 level. Respondent did not perform the surgery to which Miguel B[redacted] had consented: namely, refusion with autologous iliac crest bone.

F. Due to swelling and the formation of a hematoma in his neck, patient Miguel B[redacted] encountered severe respiratory distress following the surgery. At 8:00 a.m., the following morning,

respondent examined patient Miguel B[redacted] and wrote in the patient's chart: "[patient] . . . [q]uite uncomfortable from swollen neck, tracheal phlegm - difficulty expectorating. . . [r]ight post neck pain relieved . . . [d]oes not swallow . . . [w]ound drainage modest . . . [w]ill leave neck drain in situ [*sic*] since swelling considerable . . . ."

G. Although respondent was advised by telephone, at or about 11:30 a.m., that ". . . blood draining from drain" and, at or about 1:50 p.m., further was advised by telephone that "[r]ight neck swollen, still bleeding a lot . . .[,]" respondent did not attempt to see patient Miguel B[redacted] but, instead, requested that patient Miguel B[redacted] be examined by the anesthesiologist and a respiratory therapist. At or about 2:30 p.m., respondent telephonically ordered that patient Miguel B[redacted] be transferred to the intensive care unit [ICU] and asked that the anesthesiologist arrange to have patient Miguel B[redacted] seen by a pulmonologist. The standard of care in the medical community requires that the operating surgeon personally provide post-operative care to the patient unless he has turned over the patient's care to a qualified physician and surgeon who agrees to provide the care.

H. The pulmonologist, Dr. K. Pittokopitis, arrived at or about 6:00 p.m. and, upon examining

patient Miguel B[redacted], observed "blood in the left side of pharynx and a grossly swollen mass on the right . . . ." Dr. Pittokopitis attempted a bronchoscopy and endotracheal intubation. Patient Miguel B[redacted] developed cardiopulmonary arrest. Respondent arrived during the attempted resuscitation of patient Miguel B[redacted], at or about 7:15 p.m., over four hours after being advised on the patient's deteriorating condition. Respondent opened the neck wound and performed a tracheostomy to obtain an air passage. Patient Miguel B[redacted], however, could not be resuscitated and died at or about 7:51 p.m.

I. Respondent, as a trained neurosurgeon, knew or should have known how to recognize a post-operative wound hematoma such as patient Miguel B[redacted]'s and manage it appropriately. Respondent's failure to come to the hospital, to evaluate patient Miguel B[redacted]'s condition personally, and to provide the necessary post-operative care to patient Miguel B[redacted] coupled with his decision to have the post-operative care performed by an anesthesiologist, a pulmonologist, and a respiratory therapist was a gross departure from the standard of care in the medical community.

SECOND CAUSE OF ACTION

(Incompetence: Patient Miguel B[redacted])

5. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), in that respondent was incompetent in the care and treatment of patient Miguel B[redacted], as follows:

A. Complainant refers to, and by this reference, incorporates herein, paragraph 4, subparagraphs A through I, inclusive, above, as though fully set forth.

THIRD CAUSE OF ACTION

(Repeated Negligent Acts:

Patients Miguel B[redacted] and Mary L. C[redacted])

6. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that respondent committed repeated negligent acts in the care and treatment of patients Miguel B[redacted] and Mary L. C[redacted], as follows:

A. Complainant refers to, and by this reference, incorporates herein, paragraph 4, subparagraphs A through I, inclusive, above, as though fully set forth.

B. On or about May 28, 1990, patient Mary L. C[redacted] consulted respondent regarding her intractable pain and with symptoms of lumbar disc disease. Patient Mary L. C[redacted] had had three prior back surgeries, all performed by respondent.

C. Although respondent initially believed that patient Mary L. C[redacted] would not benefit from additional surgery, he again consulted patient Mary L.

C[redacted], on or about July 5, 1990, and advised her that her pain may be relieved through bilateral compression of the L-5 nerve roots. Respondent further advised patient Mary L. C[redacted] as well as her husband of the complexity and problems associated with such surgery and corresponding need for pedicle screw stabilization and fusion which would be required for successful surgery. Patient Mary L. C[redacted] and her husband agreed to having respondent perform the surgery which was scheduled for July 19, 1990.

D. According to respondent's preoperative notes, respondent had planned to decompress patient Mary L. C[redacted]'s L-4-5 level bilaterally and insert pedicle screws for stabilization. Prior to commencing the July 19th scheduled surgery, however, respondent did not order x-rays of patient's Mary L. C[redacted] spine in order to determine the area of the proper vertebrae to be compressed. Instead, respondent relied on visualization and fluoroscopy of patient Mary L. C[redacted]'s spine to determine the proper vertebrae for the intended surgery. Respondent's visualization was inaccurate and, as a result, respondent decompressed patient Mary L. C[redacted]'s L-3, rather than L-4-5, vertebrae and inserted the pedicle screws at the L-2-3, rather than L-4-5, level. Upon realizing his mistake following his completion of the surgery, respondent rescheduled patient Mary L. C[redacted] for surgery at the

L-4-5 level which was performed on July 30, 1990. The combined surgeries performed by respondent on July 19th and 30th resulted in compression of patient Mary L. C[redacted]s vertebrae from the L-2 to L-5 levels. Respondent did not remove the pedicle screws which he placed during the July 19th surgery.

E. The standard of care in the medical community requires a neurosurgeon such as respondent to obtain adequate localization to identify the correct vertebral level before proceeding with any type of back surgery. If adequate localization cannot be determined by visualization or fluoroscopy, a neurosurgeon is obligated to take additional precautions, including the taking of additional x-rays, to insure that he or she will be operating at the intended vertebral level.

FOURTH CAUSE OF ACTION

(False Representation of Facts: Patient Miguel B[redacted]

7. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2261 in that respondent knowingly made or signed a certificate or other document directly or indirectly related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts in the care and treatment of patient Miguel B[redacted], as follows:

A. Complainant refers to, and by this reference, incorporates herein, paragraph 4, subparagraphs A through G,

inclusive, above, as though fully set forth.

B. In patient Miguel B[redacted]s discharge summary prepared by respondent on or about June 9, 1990, respondent included: "Postoperative AP and lateral cervical spine films [taken on or about June 8, 1990] show good positioning of the C-5-6 interbody fusion and excellent alignment." Said discharge summary was erroneous in that the films did not show "good positioning of the C-5-6 interbody fusion."

C. On a note, dated August 16, 1990, handwritten by respondent and made part of patient Miguel B[redacted]s progress records, respondent recorded that he had "reopen[ed] cervical 5-6 . . ." when, in fact, respondent had performed surgery to that area of the patient's spine for the first time.

FIFTH CAUSE OF ACTION

(False Medical Records: Patient Miguel B[redacted])

8. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2261 in that respondent altered or modified medical record(s), with fraudulent intent, or created false medical record(s), with fraudulent intent in the care and treatment of patient Miguel B[redacted], as follows:

A. Complainant refers to, and by this reference, incorporates herein, paragraph 4, subparagraphs A through I, inclusive, above, as though fully set forth.

B. Complainant refers to, and by this reference incorporates herein, paragraph 7, subparagraph B and C, inclusive, above, as though fully set forth.

SIXTH CAUSE OF ACTION

(Gross Negligence: Patient Mary L. C[redacted])

9. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that respondent committed gross negligence in the care and treatment of patient Mary L. C[redacted], as follows:

A. Complainant refers to, and by this reference incorporates herein, paragraph 6, subparagraphs B through E, inclusive, above, as though fully set forth.

SEVENTH CAUSE OF ACTION

(Incompetence: Patient Mary L. C[redacted]

10. Respondent John Andrew McRae, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), in that respondent was incompetent in the care and treatment of patient Mary L. C[redacted] as follows:

A. Complainant refers to, and by this reference, incorporates herein, paragraph 6, subparagraphs B through E, inclusive, above, as though fully set forth.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number C-24327, heretofore issued to respondent John Andrew McRae, M.D.; and prohibiting supervision of physician assistants.

2. Ordering respondent to pay the Division the actual and reasonable costs of the investigation, prosecution and enforcement of this case;

3. Taking such other and further action as the Division deems proper.

DATED: September 5, 1995.

John C. Lancara for

DOUG LAUE
Acting Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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